

# Oregon

## Chiropractic Practices and Utilization Guidelines



Last updated 1991

Common  
Neuromusculoskeletal  
Conditions

## TABLE OF CONTENTS

Acknowledgments.....	3
Foreword.....	5
Introduction.....	7
Chapter I      Goals and Objectives for Clinical Practice.....	9
Chapter II     Chiropractic Diagnostic and Treatment Procedures.....	13
Chapter III    Record Keeping and Report Writing.....	17
Chapter IV    Chiropractic Management Algorithm..... <i>Refer to Nov 2017 Revision on OBCE website</i>	19
Chapter V     Treatment Parameters for Common Neuromusculoskeletal Conditions.....	25
Chapter VI    Chiropractic Glossary of Commonly Used Terms.....	29
Chapter VII    References.....	35

This page intentionally left blank.

## ACKNOWLEDGMENTS

The Oregon Board of Chiropractic Examiners would particularly like to acknowledge the following members of the Oregon Chiropractic Practices and Utilization Guidelines Committee. Also, special thanks to past and present board members.

### Oregon Chiropractic Practices and Utilization Guidelines Committee

Michael G. Lang, D.C.  
Chairman

John Colwell, D.C.	Elizabeth Olsen, D.C.
Steven Cranford, D.C.	David Peterson, D.C.
Meridel Gatterman, D.C.	Edmonde Samuel, D.C.
Mitchell Haas, D.C.	Arthur Walker, D.C.
Lester Lamm, D.C.	Michael Whitton, D.C.
Steven Oliver, D.C.	

### 1989 - 1991 Board Members:

Steven Gardner, D.C. President  
Richard Gorman, D.C. Vice-President  
Gary Zimmerman, D.C. Secretary  
William McIlvaine, D.C.  
Jeanette Launer, J.D.  
Janis Isselman, D.C.  
Bonnie McDowell, R.P.T, D.C.  
Mitzi Naucner, J.D.

### Reference Documents:

Chiropractic Advisory Committee, Department of Labor & Industries, State of Washington

Chiropractic Standards of Practices and Utilization Guidelines in the  
Care and Treatment of Injured Workers

Council on Chiropractic Education  
Clinical Competencies

This page intentionally left blank.

## FOREWORD

By Steven L. Gardner, D.C.  
President, Oregon Board of Chiropractic Examiners

The Oregon Board of Chiropractic Examiners is pleased with volume I of this document. It combines the efforts of many fine Chiropractic Physicians with the academic perspective of Western States Chiropractic College. It is the result of research, hard labor, and healthy debate. The Board respectfully acknowledges that research provided both insight and language which was adopted here, however it is by design that this document was written by and for Oregonians.

The Board intends and believes that these guidelines will be helpful to all Oregon Chiropractors. Furthermore, and paramount to the Board, is that this guide will continue to refine the professional care provided to the Chiropractic patients of Oregon.

Future volumes will include other areas that are defined in the Chiropractic Practices Act of Oregon. The next volume of the document will include guidelines for Minor Surgery, Proctology, Obstetrics and Gynecology.

## CHALLENGES

Dr. Melvin Turner was a graduate of Palmer Chiropractic College and the first chiropractor in Walla Walla Valley. He opened his office on Cherry Street in 1901. He found the practice of chiropractic very challenging. Every time he treated a patient he was jailed for "practicing medicine without a license". It was reported to have happened five times in one day. Chiropractors were not licensed in his community yet. Neither Dr. Turner nor his patients were discouraged however, each time he went to jail his patients paid the one dollar bail to set him free so he could treat others. You see, Dr. Turner provided an excellent service for his patients and they needed him. In fact, they demanded chiropractic care and although it took years, Dr. Turner was finally licensed. Today, Dr. Turner's son and grandson continue to provide excellent chiropractic care to the people in the Walla Walla Valley.

Ninety years later chiropractic physicians still find their practices very challenging. No matter what challenges are to be faced, chiropractic physicians must always place the welfare of their patients first. After all, it is only because of the patients that chiropractic exists. Practicing chiropractic in Oregon is a blessing and a privilege.

This page intentionally left blank.

## INTRODUCTION

By Michael G. Lang, D.C.  
Chairman, Peer Review Committee

In 1989, the Oregon Board of Chiropractic Examiners, in keeping with its licensing and regulatory responsibilities, elected to direct the Peer Review Committee of the OBCE to coordinate the development of a document that would be of assistance to the Chiropractic profession as it pertains to outlining health care guidelines for the chiropractic physician.

To accomplish this objective, the Peer Review Committee in turn formed a 12 member Oregon Chiropractic Practices and Utilization Guidelines Committee. The composition of this group reflects a substantial amount of clinical field experience as well as a strong academic background from Western States Chiropractic College.

It is the desire of the OBCE to help ensure that a desirable level of both clinical competence and quality of care are rendered by each licensed practitioner. This document is an attempt to provide a guideline for assuring that quality and competence.

It should be emphasized that these guidelines are not designed to cover the complete scope of chiropractic practice in Oregon, but rather focus on the care and management of the common neuromusculoskeletal conditions that are encompassed within that scope of practice.

Finally, these guidelines are an expression of clinical experience and related research. As new research is done and additional clinical experience is gained, corresponding modifications will be appropriate to supplement the original consensus process.



This page intentionally left blank.

## CHAPTER I

### GOALS AND OBJECTIVES FOR CLINICAL PRACTICE

As a primary health care provider and as a portal of entry to the health delivery system, an Oregon chiropractic physician is led by these goals and accomplishes their associated objectives.

#### I. Therapeutic Relationship

A. GOAL: Establish a satisfactory relationship with the individual seeking care and determine the nature of health problem(s) being presented.

#### B. OBJECTIVES:

1. Establish rapport in an atmosphere of physical comfort conducive to information gathering.
2. Provide for the presence of a third party, as required, to assist or observe in recording information, allaying apprehension, or other circumstances.
3. Elicit a thorough case history through written or oral means and provide a permanent record of findings with due regard for a patient's differing ethnic, cultural or linguistic background.
4. Include within each case history, chief complaint, present health pattern and relevant past health, injury or disability factors.
5. Assess the reliability of information presented.

#### II. Examination

A. GOAL: Provide such examination and diagnostic procedures and/or refer for additional diagnosis and management plan.

#### B. OBJECTIVES:

1. Specify which examination and diagnostic procedures are pertinent to the patient's complaint and present condition of health.
2. Perform such examination and diagnostic procedures within statutory scope of practice and clinic capabilities and consistent with efficient exploration of the condition presented.
3. Assess the sensitivity, specificity and predictive value of examination procedures selected.
4. Conduct examination and diagnostic procedures in an objective manner, remaining impartial with respect to etiology and extent of condition.
5. If referring for outside examination or diagnostic procedures, explain the rationale for additional testing to the patient.
6. Assess historical and physical data to identify contraindications or non-indications for chiropractic care.

7. If referring to another health care provider, include the courtesy of an appropriate referral report as required.
8. Accurately record examination findings in the patient's case file consistent with common practice.

### III. Diagnosis

A. GOAL: Arrive at provisional diagnoses or clinical impressions consistent with the presenting complaint(s) and the results of examination and diagnostic procedures conducted.

B. OBJECTIVES:

1. Gather and interpret the results of all examination and diagnostic procedures, differentiating between normal and abnormal findings and determining the relevance of each of the presenting complaint(s).
2. Select subsequent evaluation procedures that are appropriate to the continued investigation of the patient's condition.
3. Differentiate between clinical entities common to chiropractic practice.
4. Rule in or rule out the pathophysiological processes responsible for the patient's presenting complaint(s).
5. Record objectively supported provisional diagnoses or clinical impressions, complicating factors and/or concomitant conditions using common diagnostic lexicon.

### IV. Prognosis and Decision to Treat and/or Refer

A. GOAL: Arrive at a provisional prognosis and determine whether to accept the patient for chiropractic care and/or refer to another health care provider. Consider the risk and cost/benefit ratios incurred.

B. OBJECTIVES:

1. Determine the patient's provisional prognosis.
2. Determine whether the condition is amenable to chiropractic care and is within the scope of chiropractic practice.
3. If any portion of the patient's condition is not treatable within the scope of chiropractic practice, refer to the appropriate health care provider in an expedient and professional manner.

### V. Treatment Plan

A. GOAL: Decide upon and initiate an efficient and effective treatment and regimen.

B. OBJECTIVES:

1. Use only those treatment procedures and modalities within the statutory scope of practice and consistent with a fair appraisal of the cost/benefit ratio.

2. Record and date the treatment plan, including expected length and intensity of treatment, in the case file.
3. If there are any general or specific considerations or contraindications for care, note them in the case file and modify the plan appropriately and/or refer the patient to another provider.
4. Educate the patient about his/her condition, diagnosis and rationale for the treatment plan; outlining expectations and significant risks. Obtain consent from the patient.
5. Record the course of treatment in a format that permits interpretation by health care providers.

## VI. Monitoring

A. GOAL: Assess the effectiveness of the treatment plan and make appropriate changes in case management as required.

### B. OBJECTIVES:

1. Perform ongoing assessment of both subjective and objective findings; noting them in the case file.
2. Identify the need and extent of re-examination necessary to assess significant exacerbations or deviations from planned recovery.
3. Conduct such examinations and refer for consultation to adequately monitor changes in the patient's condition.
4. Evaluate new objective findings, integrating them with historical data, and changing diagnoses and treatment appropriately, including referral to another provider in the best interest of the patient.
5. Provide sufficient information in reports to be authorized by a third party representative of the patient to permit informed understanding of patient progress and intelligent decision making on authorization of services.

## VII. Discharge

A. GOAL: Decide on the appropriate termination of services either at the endpoint of treatment or when no further improvement in the patient's condition can reasonably be expected. This responsibility includes the determination of follow-up care when necessary.

### B. OBJECTIVES:

1. Release the patient from corrective care:
  - a. At the request of the patient, or
  - b. When the objectives of the treatment plan have been achieved, or
  - c. When no further significant improvement in objective signs can be anticipated due to further chiropractic treatment or to passage of time.
2. Determine necessity of follow-up care and refer or instruct as appropriate.

This page intentionally left blank.

## CHAPTER II

### CHIROPRACTIC DIAGNOSTIC AND TREATMENT PROCEDURES

#### SEQUENCE OF CLINICAL APPLICATION

The methods for appropriate clinical decision making must be consistent with primary health care provisions and portal of entry procedures. Each step taken in reaching a clinical impression provides an opportunity for the chiropractic physician to decide to continue further without consultation or referral. The following is a general sequence of procedures that is commonly followed by the chiropractic physician. It is intended as a guideline, not as an exhaustive list.

- I. Intake Interview
  - A. History of presenting illness
  - B. Past health history
  - C. Family health history
  - D. Personal and social history
- II. Examination and Diagnostic Procedures
  - A. Physical examination
    1. General
    2. Regional area of complaint
    3. Chiropractic examination of spine and extremities
  - B. Psycho-social Assessment
  - C. Laboratory examination (ordered or performed when clinically indicated)
  - D. Diagnostic imaging (ordered or performed when clinically indicated)
  - E. Special examinations (ordered or performed when clinically indicated)
    1. Gynecological examination
    2. Proctological examination
    3. Obstetrical examination
    4. Minor surgical examination
    5. Electrodiagnostic evaluation
    6. Vascular evaluation
- III. Diagnostic and/or Clinical Impression
- IV. Prognosis and Decision to Treat and/or Refer
- V. Chiropractic Therapeutic Care and Patient Management
- VI. Re-evaluation and Appropriate Modification of the Diagnostic Impression and Treatment Plan
- VII. Conclusion of Treatment

## CHIROPRACTIC DIAGNOSTIC PROCEDURES

### I. History

A necessary component of clinical fact finding through subjective offerings by the patient. The history may include, but is not limited to, the following:

- A. Presenting condition
  - 1. Location
  - 2. Chronology
  - 3. Quality
  - 4. Severity
  - 5. Setting (circumstances)
  - 6. Modifying factors
  - 7. Associated symptoms (review of systems)
  - 8. Prior treatment(s)
- B. Past health history
  - 1. Accidents and injuries
  - 2. Previous illnesses
  - 3. Surgeries
  - 4. Medications
- C. Family health history
  - 1. Parents
  - 2. Grandparents
  - 3. Siblings
- D. Personal and social history
  - 1. Description of job
  - 2. Exercise
  - 3. Diet
  - 4. Habits

### II. Examination and Diagnostic Procedures

The examination and diagnostic procedures may include:

- A. Physical examination
  - 1. Vitals
  - 2. Heart, lungs and abdomen
  - 3. EENT
  - 4. Integumentary examination
  - 5. Orthopedic and neurological tests
  - 6. Static and motion palpation of the spine and extremities
  - 7. Postural analysis
  - 8. Muscle testing including dynamic, isokinetic, static and manual
- B. Psycho-social assessment
- C. Laboratory examination

Clinical laboratory testing may be necessary when the history and/or other examination findings indicate.

D. Diagnostic imaging

While diagnostic imaging procedures may be vital to diagnosis and case management, the decision to utilize any diagnostic imaging procedure should be based on a demonstrated need (medical necessity) following an adequate case history and physical examination.

E. Special examinations

1. Gynecological examination
2. Proctological examination
3. Obstetrical examination
4. Minor surgical evaluation
5. Electrodiagnostic evaluation
6. Vascular evaluation

F. Other clinically indicated examination procedures that comply with the OBCE rules.

III. Diagnosis and/or clinical impression

- A. Severity
- B. Acute vs. chronic
- C. Location of lesion and/or disease
- D. Etiology
- E. Complicating factors
- F. Concurrent conditions

IV. Prognosis and decision to treat and/or refer

The decision to treat and/or refer is made after appropriate examination and a working diagnosis has been established. Consideration of the contraindications to the chosen treatment should be taken at this time as well as consideration of consultation and/or acquiring a second opinion.

When possible and/or appropriate a prognosis should be given at the time that a diagnosis is made. The prognosis may change as the condition of the patient and the response to treatment changes. A later referral may also be considered following an appropriate therapeutic trial.

V. Chiropractic Therapeutic Care and Patient Management

A. Manual therapy

1. Adjustment
2. Manipulation
3. Mobilization
4. Soft tissue manipulation

B. Physiological therapeutics

1. Heat and/or cold
2. Hydrotherapy
3. Electrotherapy
4. Phototherapy
  
5. Mechanotherapy



- 6. Therapeutic and/or rehabilitation exercise
    - 7. Orthotics
  - C. Nutritional
  - D. Counseling
  - E. Treatment in special areas
    - 1. Gynecology
    - 2. Obstetrics
    - 3. Proctology
    - 4. Minor surgery
- VI. Re-evaluation, etc.
- VII. Conclusion of Treatment

## CHAPTER III

### RECORD KEEPING AND REPORT WRITING

The quality of a physician's health care is dependent on his/her ability to gather, organize, analyze and make decisions on clinical data. Good decisions are the result of accurate and complete facts being retrievable from a patient's records.

Therefore, documentation of the patient's health history, presenting complaint(s), progression of care, diagnosis, prognosis and treatment plan should be reflected in the record keeping and written reports of the patient file. Some aspects of this file have been included in Chapter I. Components of this file should include:

#### I. Patient History and Examination Records

There is considerable variation in how physicians develop and record a clinical history and examination findings. The reader is referred to Chapter I, Sections I and II for a summary of the suggested guidelines.

#### II. Chart Notes

Chart notes should be recorded at each visit in a form which may be understood by the chiropractor's peers. While the patient's history indicates their status at the time of the initial visit or at the onset of a new condition, the progress record (often called chart notes) reflects the patient's state of health at subsequent points of time.

The minimum acceptable records should create a story of the patient's response to the physician's management of their case. This story should be legible and clear enough to allow a peer to assume management of the case after an initial review of the chart notes. Full SOAP charting at each visit, while recommended, is not required, but components of the file should include:

##### A. Subjective complaints

The patient's complaints should be recorded at each visit (in the patient's own words when possible) indicating improvement, worsening or no change.

##### B. Objective findings

Changes in the clinical signs of a condition should be noted at each visit in the doctor's own words.

##### C. Assessment or diagnosis

It is not necessary to update this category at each visit. However, periodic clinical re-evaluations should be performed and these results included in the daily entries with any alterations in the diagnosis.

##### D. Plan of management

A provisional plan of management should be recorded initially and further entries should be made as this plan is modified and/or as a patient enters a new phase of treatment. Changes in procedures should be noted.

##### E. Procedures

Daily recording of procedures performed should include descriptions of manipulations performed, soft tissue techniques, modalities used, exercises prescribed, nutritional supplementation or prescribed diet and activity instructions. Patient response to therapies should be noted.

### III. Written Reports

- A. History
  - 1. Presenting complaints
  - 2. Past health history
  - 3. Family health history
  - 4. Personal and/or social history
- B. Examination findings
- C. Assessment, diagnosis or clinical impression
- D. Plan of management and/or response to treatment
- E. Prognosis and/or outcome expectations

### IV. Ancillary Documentation

- A. Correspondence (sent and received)
- B. Specialty reports (diagnostic imaging, lab nerve conduction studies, etc.)
- C. Communications (telephone conversations, dialogue with family or friends of the patient, etc.)

## CHIROPRACTIC MANAGEMENT ALGORITHM

~~This algorithm develops a clinical management path for the chiropractic patient; to facilitate their recovery in the shortest time and the most cost effective manner possible. The algorithm is presented primarily to organize the chiropractic physician's application of diagnostic and therapeutic interventions. The emphasis is on management of the patient and not on management of a particular pathophysiology. This is because any one patient may present with multiple pathophysiologies or their clinical course may progress through multiple pathophysiological states requiring management modification.~~

~~An algorithm provides a visual tool for communication of expected diagnostic and therapeutic applications from the Oregon Board of Chiropractic Examiners to practicing chiropractors, from the individual D.C. to his patient and from the D.C. to third parties involved with any particular patient. Key points are defined for the referral to another physician and/or health care provider and for the reporting of information to patients and to involved third party payors. Concurrent allopathic and/or psychological management is incorporated into this scheme and the algorithm identifies the usual protocol for chiropractic management alternatives of a patient at maximum clinical improvement.~~

~~The algorithm is organized into three basic sections: diagnostics, therapeutics and maximum clinical improvement. The diagnostics section includes history, examination, data collection, special studies or examinations ordered by the D.C., allopathic procedures ordered by the D.C. and allopathic procedures ordered by any consulting discipline; including but not limited to, allopathic, osteopathic, psychiatric or psychological. The therapeutic section defines three feedback loops originating with the clinical reevaluation of patients who are showing poor progress, multiple exacerbations or no response to the provisional management plan. The maximum clinical improvement section defines four categories of patients and describes appropriate management alternatives at that juncture.~~

~~The sequence of this algorithm begins with consultation, history of present illness, physical examination and collection of data to confirm and analyze the medical history. Based on this information a clinical impression is rendered. This initial impression may be modified by any special studies or examinations ordered as they may identify complicating conditions which will naturally modify the resulting treatment plan or prognosis.~~

~~At this point, prior to treatment, the D.C. may desire a medical or surgical consultation. The consultation may result in a referral for medical management or feedback into chiropractic management with concurrent medial treatment. Based on these clinical impressions, a provisional treatment plan is formulated with a time line and goals for expected subjective and objective response. After reporting this to the patient, treatment is initiated.~~

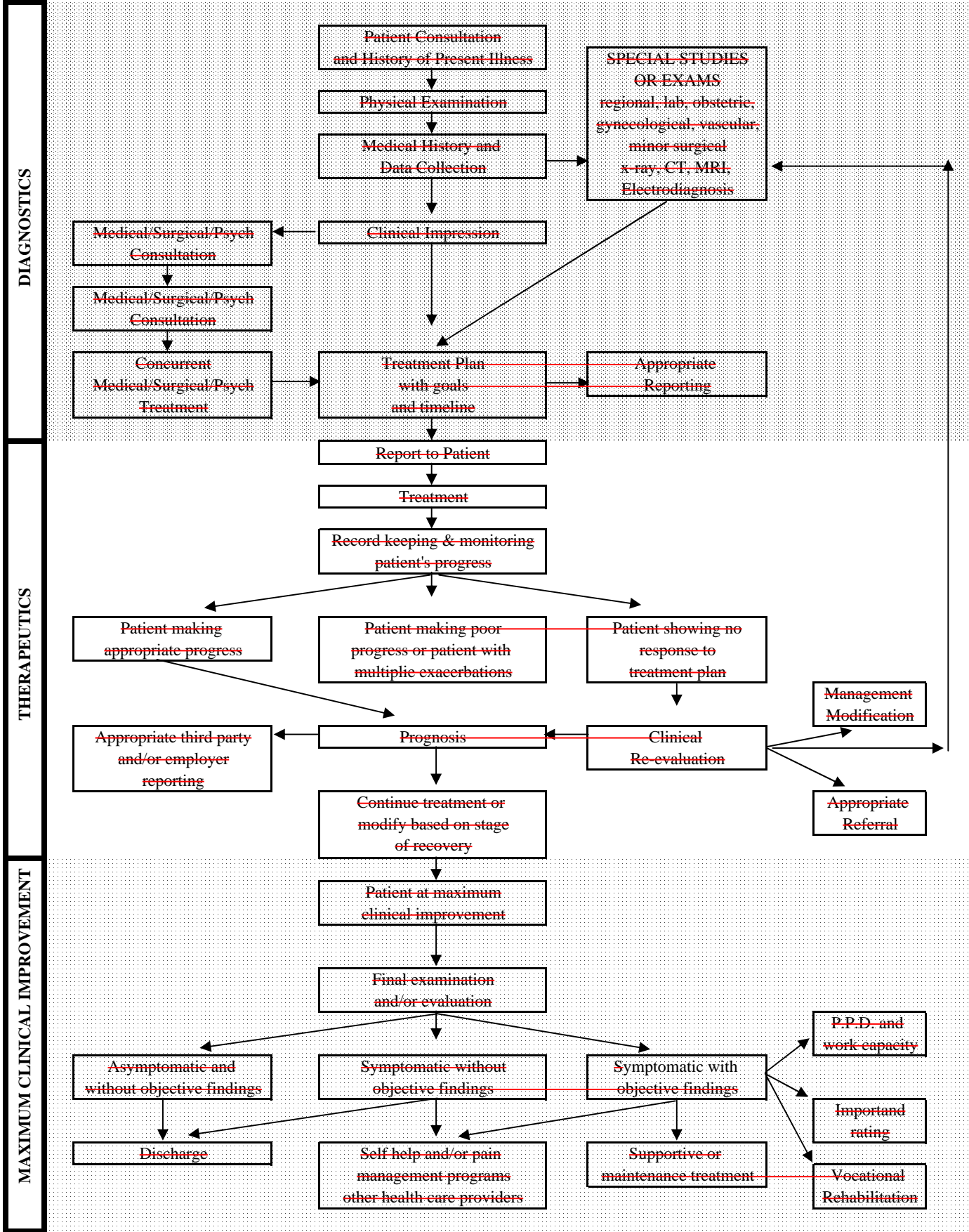
~~Treatment response is monitored and documented objectively and subjectively in the patient's records. Appropriate progress to treatment usually confirms the initial clinical impressions and a more accurate prognosis can be formulated and reported to the patient, third party payors and~~

~~employers, if indicated. Assuming continued improvement with treatment, the management may be modified based on the patient's stage of recovery until maximum clinical improvement is reached.~~

~~For patients making poor progress, patients with multiple exacerbations or patients showing no response to treatment, clinical re-evaluation is indicated. At this point, the D.C. may elect four courses of action: **first**, to redefine the prognosis, goals and time line and continue with treatment; **second**, to modify the patient's management with his consent; **third**, to refer the patient to another physician and/or health care provider; **fourth**, to perform other special studies or examinations as indicated by the re-evaluation. This final option loops into the diagnostic section of the algorithm allowing the clinical impressions to be altered or modified. This resulting modified impression and treatment plan may include additional chiropractic or conservative therapies, concurrent allopathic or psychological treatment or referral to other disciplines. After the patient's consent is obtained, modified treatment is continued.~~

~~Usually four groups of patients exist at maximum clinical improvement. Those who are asymptomatic and without objective findings are discharged. Those who are asymptomatic with objective findings may be clinically re-evaluated and their management modified or given an appropriate referral. Patients who are still symptomatic and retain objective findings may be referred for impairment rating, work capacity evaluation and/or vocational rehabilitation if it is appropriate. These patients should be instructed in or referred to self-help and pain management programs and often require some supportive or maintenance treatment. Patients who are symptomatic but without objective findings may be instructed in or referred to self-help or pain management programs, other appropriate health care providers or discharged.~~

~~This algorithm was developed utilizing the combined experience of chiropractic physicians and the academic departments at Western States Chiropractic College and is not considered the only approach to chiropractic patient management in the State of Oregon. Further refinement and validation of this scheme is expected. We are not implying that this algorithm actually improves the clinical outcome of any particular patient group progressing through a course of chiropractic treatment. However, it does represent a tool for clinical decision making and stresses three chronological phases in patient management: diagnostics, therapeutics and maximum clinical improvement. It also allows for feedback loops returning to the diagnostic section based on information obtained in the therapeutics section of this model.~~



This page intentionally left blank.

## CHAPTER V

### TREATMENT PARAMETERS FOR COMMON NMS CONDITIONS

The following treatment parameters are to be used only as guidelines. These are estimates of treatment and/or healing time for commonly encountered categories of neuromusculoskeletal conditions. Disorders outside the NMS system are not addressed by this document. As stated in the preamble, this is an ongoing and dynamic process. These parameters will be amended or modified as new research and expert clinical judgments fill in the inevitable gaps in this process.

The suggested parameters do not reflect the protracted healing time and disability that may result from individual conditions complicated by such factors as previous injuries, congenital or developmental defects, systemic diseases, degenerative disorders, obesity, smoking, psychosocial compromise and others. In such conditions, or if the natural history of an injury is interrupted by aggravations, exacerbations, or flare-ups; applicable treatment guidelines could be modified or extended. However, benefit of care should be supported by subjective and objective documentation.

#### CATEGORY I

##### 0 - 6 WEEKS TREATMENT

1. Mild-moderate strain
2. Mild sprain
3. Mechanical/joint dysfunction (uncomplicated)
4. Subluxation (uncomplicated)
5. Acute facet syndrome
6. Contusion
7. Mild-moderate tendinitis, capsulitis, bursitis, synovitis
8. Mild sacroiliac syndrome
9. Acute myofascial pain syndrome
10. Mild symptomatic degenerative joint disease
11. Headaches: vertebrogenic, muscle contraction, migraine, vascular
12. Torticollis (acquired)

#### CATEGORY II

##### 2 - 12 WEEKS TREATMENT

1. Moderate-marked strain
2. Moderate sprain
3. Post traumatic mild-moderate myofibrosis
4. Post traumatic periarticular fibrosis and joint dysfunction with marked tendinitis, bursitis, capsulitis, synovitis
5. Chronic tendinitis, bursitis, capsulitis, synovitis
6. Chronic facet syndrome
7. Moderate sacroiliac syndrome
8. Chronic sacroiliac syndrome with marked myofascial pain syndrome
9. Chronic myofascial pain syndrome
10. Mechanical/joint dysfunction (complicated)
11. Subluxation (complicated)
12. Moderate symptomatic degenerative joint disease



13. Mild inter-vertebral disc syndrome w/o myelopathy
14. Chronic headaches: vertebrogenic, muscle contraction, migraine, vascular
15. Mild temporomandibular joint dysfunction
16. Symptomatic spondylolisthesis
17. Mild clinical joint instability

### CATEGORY III

#### 1 - 6 MONTHS TREATMENT

1. Chronic facet syndrome associated with clinical vertebral instability
2. Marked strain associated with post traumatic myofibrosis and/or joint dysfunction
3. Marked sprain with associated instability/dysfunction
4. Thoracic outlet syndromes
5. Moderate inter-vertebral disc syndrome w/o myelopathy
6. Peripheral neurovascular entrapment syndromes
7. Moderate to marked temporomandibular joint dysfunction
8. Adhesive capsulitis (frozen joint)
9. Partial or complete dislocation

### CATEGORY IV

#### 2 - 12 MONTHS TREATMENT

1. Marked inter-vertebral disc syndrome w/o myelopathy, with or without radiculopathy
2. Lateral recess syndrome
3. Intermittent neurogenic claudication
4. Acceleration/deceleration injuries of the spine with myofascial complications (whiplash)
5. Cervicobrachial sympathetic syndromes
6. Sympathetic dystrophies
7. Severe strain/sprain of cervical spine with myoligamentous complications

#### RE-ASSESSMENT

The following circumstances are offered as an indication for reassessment by the treating physician. Clinical evidence or special circumstances may support continued treatment and/or work loss beyond these guidelines.

However, lack of justification for such management would indicate the need for consultation/ second opinion and/or special examination.

1. Daily treatment exceeding two consecutive weeks
2. Treatment 3x/week exceeding six consecutive weeks
3. Authorized full time work loss for longer than four consecutive weeks
4. No objective or subjective improvement noted within the guideline parameters as outlined in this chapter.

## CHIROPRACTIC CARE

The previous categories of care pertain to acute care or initial primary therapy. Because chiropractic education and training also includes the application of rehabilitative care and maintenance care, the following provides an appropriate explanation for the administration of these forms of treatment.

REHABILITATIVE CARE: The rehabilitation protocol of Chiropractic Rehabilitation Association are the accepted clinical chiropractic standards for rehabilitative care. These are updated annually and are available in the administrative office of the Oregon Board of Chiropractic Examiners.

MAINTENANCE CARE includes both preventive and supportive care.

Preventive care involves the reduction of the incidence and/or prevalence of illness, impairments, and risk factors, and the maintenance of optimal functions.

Supportive care sustains previous therapeutic gains that might otherwise progressively deteriorate. Supportive care follows appropriate application of acute care and rehabilitation and includes concurrent life style modification efforts. In addition, it is intended to minimize complications and degenerative sequelae.

### Appropriateness of Maintenance Care

Preventive care is considered to be appropriate in an outwardly healthy individual who may have no symptoms and in whom signs of illness or impairment may be absent, minimal or subclinical. Preventive care may be inappropriate when it interferes with other appropriate primary care or when the risk of preventive care outweighs the benefits.

Supportive care is appropriate for a patient who has reached maximum therapeutic benefit (maximum medical improvement), and in whom periodic trial of therapeutic withdrawal fail. It is appropriate when rehabilitative and/or functional restorative and alternative care options, including home-based self-care and life style modification, have been considered and attempted. Supportive care is appropriate in patients who display persistent and/or recurrent signs of illness or impairments.

Supportive care may be inappropriate when it interferes with other appropriate primary care or when the risk of supportive care outweighs the benefits, e.g. physician dependence, somatization illness behavior, or secondary gain.

Guidelines for determining frequency and duration of maintenance care should be based upon the definitions provided above, with the understanding that clinical circumstances and other considerations, such as age, occupation, etc., as determined by the attending chiropractic physician, will alter duration and frequency needs and that application of care will result in reasonable differences in patient status. The determination of frequency and duration is subject to clinical judgment and at times may require peer review and further consultation.

Chiropractic doctors commonly recommend monthly visits for the purpose of supportive care. More frequent visits may be clinically justified.

Preventive care is usually applied less frequently, but would rarely be less than once per year.

This page intentionally left blank.

## CHAPTER VI

### CHIROPRACTIC GLOSSARY OF COMMONLY USED TERMS

Acute - common usage: of recent onset (hours or days); sharp; poignant; having a short and relatively severe course. (1)

Adhesion - a fibrous band or structure by which parts adhere abnormally. (1)

Adjustment - a chiropractic word of art; as defined by Janse, it is a specific form of direct articular manipulation utilizing either long or short leverage techniques with specific contacts and is characterized by a dynamic thrust of controlled velocity, amplitude and direction. (3)

Algorithm - a mechanical procedure for solving a certain kind of mathematical problem; a step-by-step method of solving a problem, as in making a diagnosis. (1)

Alignment - the act of aligning; the adjusting of a line. (2)

Analysis - separation into component parts; the act of determining the component parts of a substance (1)

Anomaly - marked deviation from the normal standard, especially as a result of congenital defects. (1)

Arthritis - inflammation of a joint. (1)

Arthrosis - degenerative joint disease of the truly movable joints of the spine or extremities. (10)

Asymmetry - lack or absence of symmetry of position or motion. Dissimilarity in corresponding parts or organs of opposite sides of the body which are normally alike. (1)

Barrier - a boundary of any kind. (2)

Anatomic barrier - the limit of anatomical integrity; the limit of motion imposed by an anatomic structure. Forcing the movement beyond this barrier would produce tissue damage. (7)

Elastic barrier (physiologic) - the elastic resistance that is felt at the end of passive range of movement; further motion toward the anatomic barrier may be induced passively. (7)

#### Chiropractic

Chiropractic practice - chiropractic is a discipline of the scientific healing arts concerned with the pathogenesis, diagnostics, therapeutics and prophylaxis of functional disturbances, pathomechanical states, pain syndromes and neurophysiological effects related to the static and dynamics of the locomotor system, especially of the spine and pelvis. (13)

Chiropractic science - chiropractic science is concerned with the investigation of the relationship between structure (primarily the spine) and function (primarily the nervous system) of the human body that leads to the restoration and preservation of health. (12)

Chronic - long standing (weeks, months or years). Symptoms may range from mild to severe. (1)

Compensation - the counterbalancing of any defect of structure or function. (1) Changes in structural relationships to accommodate for foundation disturbances and maintain balance. (5)

Contraction - a shortening or reduction in size; in connection with muscles, contraction implies shortening and/or development of tension. (1)

Contracture - a condition of fixed high resistance to passive stretch of a muscle resulting from fibrosis of the tissues supporting the muscle or joint. (1)

Diagnosis - the art of distinguishing one disease from another. (1)

Clinical diagnosis - diagnosis based on signs, symptoms and laboratory findings during life. (1)

Physical diagnosis - determination of disease by inspection, palpation, percussion and auscultation. (1)

Discogenic - common usage; caused by derangement of an inter-vertebral disc. (1)

Discopathy - any pathological changes in a disc. (3)

Displacement - removal from the normal position or place (1); as pertaining to vertebral displacement, it refers to a disrelationship of the vertebra to its relative structure. (5)

Facet Syndrome - common usage: back pain and dysfunction caused by a lesion of a posterior facet joint. This may be accompanied by referred pain in the lower extremity.

Fibrosis - the formation of fibrous tissue. (1)

Fibrositis - inflammatory hyperplasia of the white fibrous tissue of the body, especially of the muscle sheaths and fascial layers of the locomotor system. (1)

Fixation - (dynamic fault) - the state whereby articulation has become temporarily immobilized in a position which it may normally occupy during any phase of physiologic movement. The immobilization of an articulation in a position of movement when the joint is at rest, or in a position of rest when the joint is in movement. (8)

Functional - affecting the function but not the structure; said of disturbances with no detectable organic cause; idiopathic. (1)

Health - a state of optimal physical, mental and social well-being and not merely the absence of disease and infirmity. (1)

Hyper - beyond excessive. (1)

Hypo - under or deficient (1)

Instability - quality or condition of being unstable; not firm, fixed or constant. (15)

Ischemic compression - application of progressively stronger painful pressure on a trigger point for the purpose of eliminating the point's tenderness. (4)

Joint dysfunction - joint mechanics showing area disturbances of function without structural change--subtle joint dysfunctions affecting quality and range of joint motion. They are diagnosed with the aid of motion palpation, and stress and motion radiography investigation. (14)

Joint play - discrete, short range movements of a joint independent of the action of voluntary muscles, determined by springing each vertebrae in the neutral position. (5)

Manual Therapy - common usage: therapeutic application of manual force. Includes such procedures as massage, active relaxation, passive stretch, exercises, joint mobilization, thrust manipulation, immobilization and stabilization. (18)

Manipulation - passive maneuver in which specifically directed manual forces are applied to vertebral and extravertebral articulations of the body, with the object of restoring mobility to restricted areas. (17)

Massage - the systematic therapeutical friction, stroking and kneading of the body. (1)

Mobilization - the process of making a fixed part movable. (1) A form of manual therapy applied within the physiological passive range of joint motion and is characterized by non-thrust passive joint manipulation. (17)

Myofascial syndrome - pain and/or autonomic phenomena referred from active myofascial trigger points with associated dysfunction. The specific muscle or muscle group that causes the symptoms should be identified. (4)

Myofascial trigger point - a hyper-irritable spot, usually within a taut band of skeletal muscle or in the muscle's fascia, that is painful on compression and that can give rise to characteristic referred pain, tenderness, and autonomic phenomena. A myofascial trigger point is to be distinguished from cutaneous, ligamentous, periosteal and nonmuscular fascial trigger points. Types include active, latent, primary, associated, satellite and secondary.(4)

Myofasciitis - a) Inflammation of a muscle and its fascia, particularly at the fascial insertion of muscle to bone.  
b)Pain, tenderness, other referred phenomena, and the dysfunction attributed to myofascial trigger points. (4)

Myofibrosis - replacement of muscle tissue by fibrous tissue. (1)

Nerve interference - a chiropractic term used to refer to the interruption of normal nerve transmission (nerve energy). (5)

Neurogenic - this word is often used to mean originating in nerve tissue; "the cause of the disorder is neurogenic." (11)

Neuropathy - a general term denoting functional disturbances and/or pathological changes in the peripheral nervous system. (1)

Neurophysiologic effects - a general term denoting functional or aberrant disturbances of the peripheral or autonomic nervous systems. The term is used to designate nonspecific effects related to: a) motor and sensory functions of the peripheral nervous system; b) vasomotor activity, secretomotor activity and motor activity of smooth muscle from the autonomic nervous system, e.g., neck, shoulder, arm syndrome (the extremity becomes cool with increased sweating); c) trophic activity of both the peripheral and autonomic nervous system, e.g., muscle atrophy in neck, shoulder, arm syndrome. (15)

Objective - pertaining to those relations and conditions of the body perceived by another, as objective signs of disease. (1)

Osteophyte - a degenerative exostosis secondary to musculotendinous stress. (10)

Palpation - a) The act of feeling with the hand. (1)

Motion palpation - palpatory diagnosis of passive and active segmental joint range of motion. (5)

Static palpation - palpatory diagnosis of somatic structures in a neutral static position. (5)

Prognosis - a forecast as to the probable outcome of an attack of disease; the prospect as to recovery from a disease as indicated by the nature and symptoms of the case. (1)

Referred pain - pain felt in a part other than that in which the cause that produced it is situated. (1)

Restriction - limitation to movement. Describes the direction of limited movement in subluxated and/or dysfunctional joints. (5)

Sacroiliac Syndrome - pain over one sacroiliac joint in the region of the posterior superior iliac spine. This may be accompanied by referred pain in the leg. (9)

Scoliosis - an appreciable lateral deviation in the normally straight vertical line of the spine. (1)

Functional scoliosis - lateral deviation of the spine resulting from poor posture, foundation anomalies, occupational strains, etc., that are still not permanently established. (5)

Structural scoliosis - permanent lateral deviation of the spine; such that the spine cannot return to neutral position. (5)

Short leg - an anatomical, pathological or functional leg deficiency leading to dysfunction. (6)

Sign - an indication of the existence of something; and objective evidence of a disease, i.e. such evidence as is perceptible to the examining physician, as opposed to the subjective sensations (symptoms) of the patient. (1)

Spondylitis - inflammation of the vertebrae. (1)

Spondyloarthrosis - arthrosis of the synovial joints of the spine. (10)

Spondylolisthesis - anterior or posterior slippage of a vertebral body on its caudal fellow. (10)

Spondylolysis - is defined as an interruption in the pars interarticularis which may be unilateral or bilateral. (10)

Spondylophytes - degenerative spur formation arising from the vertebral end plates and usually projecting somewhat horizontally. (10)

Spondylosis - degenerative joint disease as it effects the vertebral body end plates. (10)

Spondylotherapy - the therapeutic application of percussion or concussion over the vertebrae to elicit reflex responses at the levels of neuromeric innervation to the organ being influenced. (3)

Sprain - joint injury in which some of the fibers of a supporting ligament are ruptured but the continuity of the ligament remains intact. (1)

Spur - a projecting body as from a bone. (1)

Strain - an overstretching and tearing of musculotendinous tissue.

Stress - the sum of the biological reaction to any adverse stimulus, physical, mental or emotional, internal or external that tends to disturb the organism's homeostasis; should these compensating reactions be inadequate or inappropriate, they may lead to disorders. The term is also used to refer to the stimuli that elicit the reactions. (1)

Subacute - less than acute, between acute and chronic. (1)

Subjective - pertaining to or perceived only by the affected individual; not perceptible to the senses of another person.

Subluxation/Vertebral - vertebral subluxation is an aberrant relationship between two adjacent articular structures that alteration in the biomechanical and/or neurophysiological reflections of these articular structures, their proximal structures, and /or body systems that may be directly or indirectly affected by them. (16)

Symptom - any subjective evidence of a patient's condition, i.e., such evidence as perceived by the patient. (1)

Syndesmophyte - inflammatory ossification of a ligament. (19)

Technique - any of a number of physical or mechanical chiropractic procedures used in the treatment of patients. (5)

Trigger point - see myofascial trigger point. (4)



This page intentionally left blank.

## CHAPTER VII

### REFERENCES

1. Saunders, W.B. Dorland's Illustrated Medical Dictionary, 27th edition
2. Thatcher, V.S. (Ed. by) The New Webster Encyclopedic Dictionary of the English Language, Avenel Books, New York 1984
3. Janse, J. History of the Development of Chiropractic Concepts; Chiropractic Terminology, NINCDS Monograph, No. 15
4. Travell and Simons, Myofascial Pain and Dysfunction, The Trigger Point Manual; Williams and Wilkins, 1983
5. Peterson, D. Western States Chiropractic College Glossary of Chiropractic Terminology, 1984
6. Canadian Memorial Chiropractic College, Glossary of Chiropractic Terminology
7. Sandoz, R. Swiss Annals, Volume VI, 1976, "Some Physical Mechanisms and Effects of Spinal Adjustments"
8. Sandoz, R. Swiss Annals, Volume VI, 1976, "Classifications of Luxations, Subluxations and Fixations of the Cervical Spine"
9. Kirkaldy-Willis, Managing Low Back Pain; Churchill Livingstone, 1983
10. Yochum, T. Two in One, A Radiologic Symposium, 1984
11. Houle, Edgar 1972
12. Griffin, L.K. 1973
13. European Chiropractic Union, 1973
14. Drum, D. The Vertebral Motor Unit and Intervertebral Foramen, in Goldstein, M. The Research Status of Spinal Manipulative Therapy Government Printing Office, Washington DC, 1975
15. Vear, H.J. 1973
16. Indexed Synopsis of ACA Policies on Public Health and Related Matters, 1987 edition, p. 18 (Approved by the House of Delegates, July 1987)
17. Gatterman, M.I. Complications of and Contraindications to Spinal Manipulative Therapy, J. Chiro 1982; 16(10):51+
18. Kaltenborn, F.M. Mobilization of the Extremity Joints, Third Edition, Olaf Norlis Bokhandel, Oslo; 1985
19. Yochum, T.R.; Rowe, LI Essentials of Skeletal Radiology, Williams & Williams, 1987